National Transgender Discrimination Survey Report on health and health care

Findings of a Study by the National Center for Transgender Equality and the National Gay and Lesbian Task Force
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Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people.

Transgender and gender non-conforming people frequently experience discrimination when accessing health care, from disrespect and harassment to violence and outright denial of service. Participants in our study reported barriers to care whether seeking preventive medicine, routine and emergency care, or transgender-related services. These realities, combined with widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care.

Our data consistently show that racial bias presents a significant, additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their health care access and outcomes dramatically worse.

KEY HEALTH CARE FINDINGS

- Survey participants reported **very high levels of postponing medical care** when sick or injured due to discrimination (28%) or inability to afford it (48%);
- Respondents faced **significant hurdles to accessing health care**, including:
  - **Refusal of care**: 19% of our sample reported being refused care due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey;
  - **Harassment and violence in medical settings**: 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctor's offices;
  - **Lack of provider knowledge**: 50% of the sample reported having to teach their medical providers about transgender care;
- Despite the barriers, the **majority of survey participants have accessed some form of transition-related medical care**; the majority reported wanting to have surgery but have not had any surgeries yet;
- **If medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination increased**;
- Respondents reported **over four times the national average of HIV infection**, 2.64% in our sample compared to .6% in the general population, with rates for transgender women at 3.76%, and with those who are unemployed (4.67%) or who have engaged in sex work (15.32%) even higher;
- Over a quarter of the respondents **misused drugs or alcohol specifically to cope with the discrimination** they faced due to their gender identity or expression;
- A staggering **41% of respondents reported attempting suicide** compared to 1.6% of the general population, with unemployment, low income, and sexual and physical assault raising the risk factors significantly.

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ABOUT THE SURVEY

Every day, transgender and gender non-conforming people bear the brunt of social and economic marginalization due to their gender identity. Advocates who work with transgender and gender non-conforming people have known this for decades as they have worked with clients to find housing, to obtain health and partnership benefits, or to save jobs terminated due to bias. Too often, policy makers, service providers, the media and society at large have dismissed or discounted the needs of transgender and gender non-conforming people in their communities, and a paucity of hard data on the scope of anti-transgender discrimination has hampered the struggle for basic fairness.

In 2008, the National Center for Transgender Equality and the National Gay and Lesbian Task Force formed a ground-breaking research partnership to address this problem, launching the first comprehensive national transgender discrimination study. Over eight months, a team of community-based advocates, transgender leaders, researchers, lawyers, and LGBT policy experts came together to create an original survey instrument. Over 7,000 people responded to the 70 question survey, providing data on virtually every significant aspect of transgender discrimination—including housing, employment, health and health care, education, public accommodation, family life, criminal justice, and identity documents.

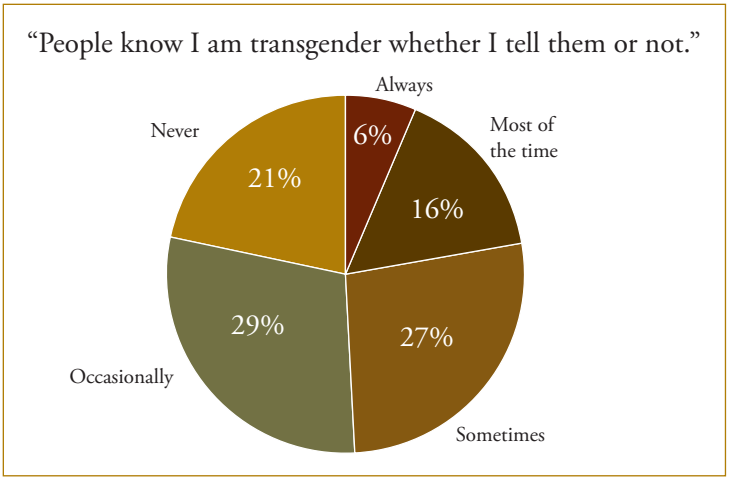
We present our health findings here, having just scratched the surface of this vast data source. We encourage advocates and researchers to consider our findings with an eye toward much-needed, in-depth future research. We expect this data set to both answer and provoke many questions for years to come about the discrimination transgender people experience. Please note that in some places, due to rounding, percentages will not add to 100%.

More extensive demographic and methodological information is presented at the end of this report. We present here some key terms and the ways in which we have used them later in this report.

Visual Non-Conformity

At the outset of our study, the research team hypothesized, based on our anecdotal experience, that those respondents whom others recognized as transgender might be at higher risk for discrimination and violence. Thus, we asked whether the respondents believed their presentation matched their gender identity: "People know I am transgender whether I tell them or not." The term we developed for the study participants who are perceived to be transgender primarily because of visual indicators is *visual non-conformers*.

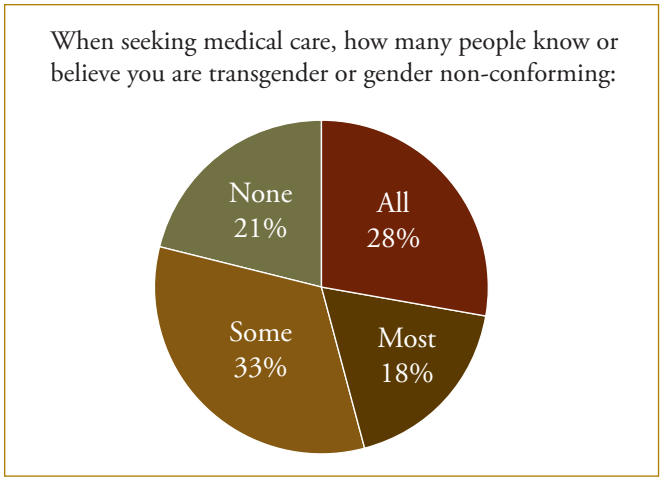
Throughout the report, we note the significance of visual non-conformity as a risk factor in eliciting anti-transgender bias and its attendant social and economic burdens.



Outness

Along with visual conformity, the research team wondered about ***outness*** in the lives of our respondents. Our question was: does self-reporting in society that one is transgender or expressing gender non-conformity have a protective effect against discrimination? In LGBT communities, there is an understanding of the process of ***coming out*** as a path to self-empowerment and public understanding. Some studies among lesbian, gay and bisexual people have shown positive effects of being out on social and economic outcomes.[1] Is the same true for transgender and gender non-conforming people? Multiple questions on levels of outness helped us establish a range of categories from "out everywhere" to "not out at all" in order to ascertain whether outness has a positive or negative effect in the lives of transgender and gender non-conforming respondents.

Twenty-eight percent (28%) of respondents said they were out to all their medical providers. Eighteen percent (18%) said they were out to most, 33% said some or a few, and 21% were out to none.



Transition

Transition is a process that some, but not all, transgender and gender non-conforming people undertake to live as a gender different from the one they were assigned at birth. For some, the journey traveled from birth sex to their current gender may involve primarily a social change but no medical component; for others, medical procedures are an essential step toward embodying their gender.

For some gender non-conforming respondents, transition as a framework has no meaning in expressing their gender—there may be no transition process at all, only recognition of a gender identity that defies convention. For other gender non-conforming people, transition is a meaningful concept that they do feel applies to their journey from birth gender to their current identity.

Respondents in our sample were asked questions that helped us identify whether or not they had embarked on a social or medical transition process in achieving embodiment of their gender. We hoped this data would be useful to us and to future researchers in considering the role of transition in (among other things) transgender health, economic security, experience of bias, and family life.

Two terms that we use throughout this report are ***medical transition*** and ***surgical transition***. Here we use surgical transition to identify those respondents who have had any type of transition-related surgical procedure. Medical transition includes any surgeries or hormonal treatment.

Various terms related to our transgender and gender non-conforming respondents

As discussed more extensively in the methodology and demographics section at the end of this report, we divided respondents into three categories for purposes of analysis: male-to-female transgender respondents, also called MTF or transgender women; female-to-male transgender respondents, also called FTM or transgender men; and gender non-conforming respondents, who are occasionally further divided into those on the female-to-male and those on the male-to-female spectrum.

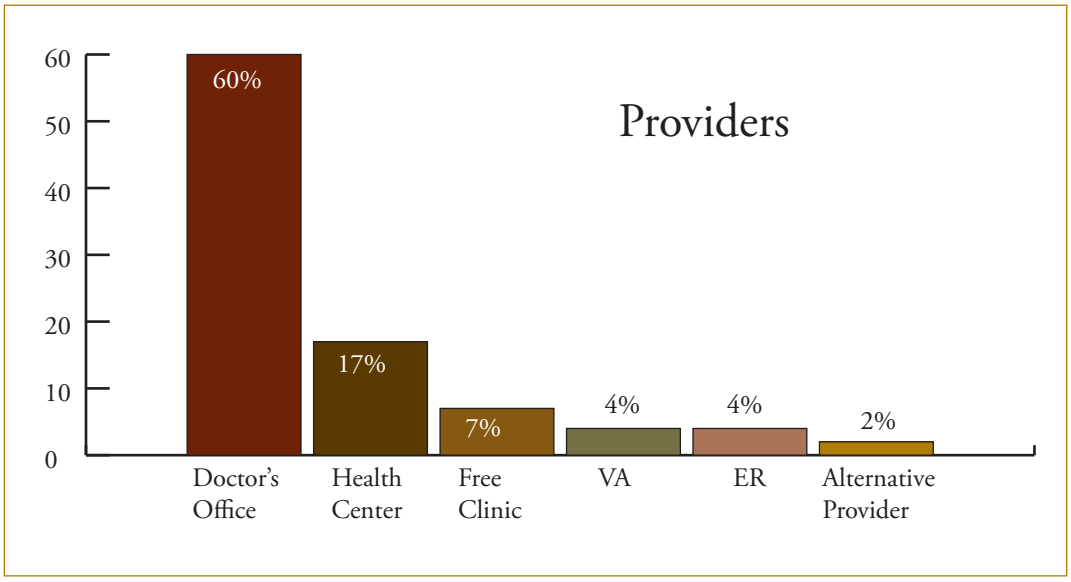
ACCESS TO HEALTH CARE

Health care settings

A majority of study participants sought care ("when you are sick or need advice about your health") through a doctor's office (60%); however a significant minority used health centers and clinics (28%). Four percent (4%) of respondents primarily used emergency rooms for care. Several studies have shown that individuals who use emergency rooms for primary care experience more adverse health outcomes than those who regularly see a primary physician.[2] Factors that correlated with increased use of emergency rooms (ERs) were:

- Race—17% of African-Americans used ERs as did 8% of Latino/a respondents;
- Income—8% of respondents earning under $10,000 per year used ERs;
- Employment status—10% of unemployed respondents and 7% of those who had lost their jobs due to bias used ERs;
- Education—13% of those with less than a high-school diploma used ERs.

Visual conformers and those who had identity documents that matched their presentation had the highest rates of using doctor's offices for their care.



Discrimination by Medical Providers

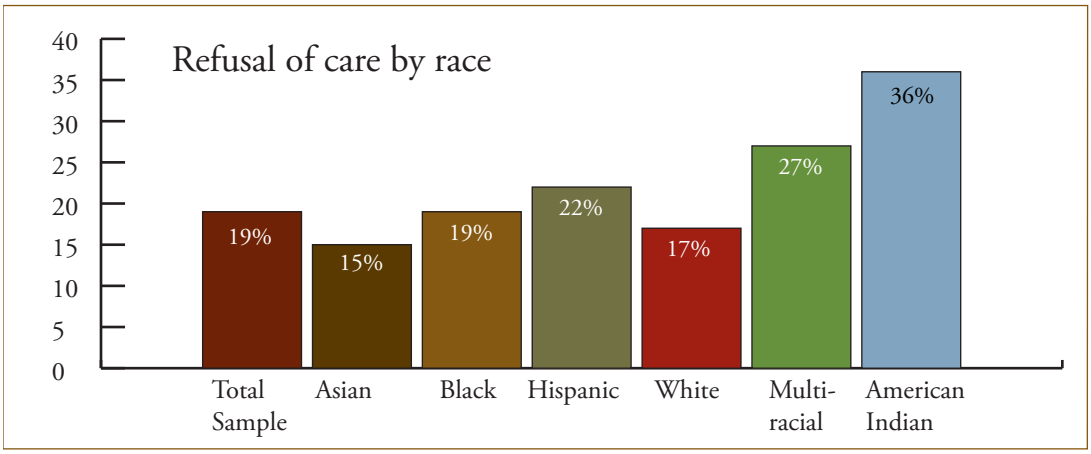
Denial of health care and multiple barriers to care are commonplace in the lives of transgender and gender non-conforming people. Subjects in our study seeking health care were denied equal treatment in doctor's offices and hospitals (24%), emergency rooms (13%), mental health clinics (11%), by EMTs (5%), and in drug treatment programs (3%).[3] Female-to-male respondents reported higher rates of unequal treatment than male-to-female respondents. Latino/a respondents reported the highest rate of unequal treatment of any racial category (32% by a doctor or hospital and 19% in both emergency rooms and mental health clinics).

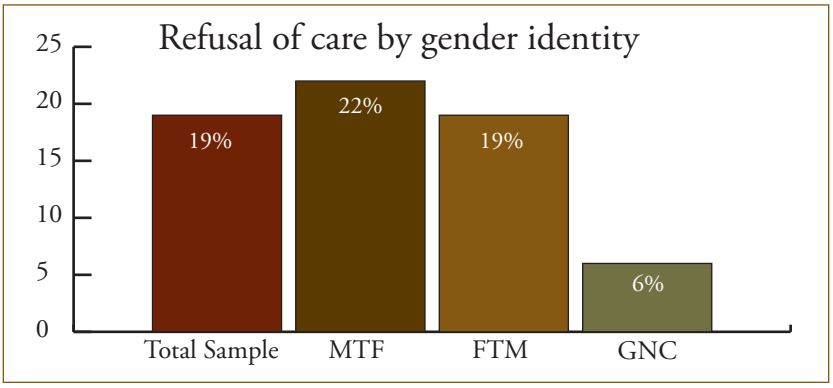
19%
of respondents were refused treatment

We also asked whether respondents had been ***denied service altogether*** by doctors and other providers.[4] Nineteen percent (19%) had been refused treatment by a doctor or other provider because of their transgender or gender non-conforming status.

Twenty-two percent (22%) of MTF respondents reported having been refused treatment altogether, whereas 19% of FTM respondents did. Respondents who had lost jobs due to bias (36%); those who engaged in sex work, drug sales or other underground economies for income (30%); those on public insurance (28%); and those living full-time as their gender identity (25%) experienced high occurrence of refusal to treat.

A doctor or other provider refused to treat me because I am transgender or gender non-conforming:





Violence and Harassment when Seeking Medical Treatment

Doctors' offices, hospitals, and other sources of care were often unsafe spaces for study participants. Over one-quarter of respondents (28%) reported verbal harassment in a doctor's office, emergency room, or other medical setting and 2% of the respondents reported being physically attacked in a doctor's office.

2%
of the respondents reported being physically attacked in a doctor's office

Those particularly vulnerable to physical attack in doctors' offices and hospitals include those who have lost their jobs (6%); African-Americans (6%); those that engaged in sex work, drug sales or other underground economies (6%); those who transitioned before they were 18 (5%); and those who are undocumented non-citizens (4%). In emergency rooms, those more vulnerable to attack include those who are undocumented (6%); those who have engaged in sex work, drug sales, or other underground economies for income (5%); those who lost their jobs (4%); and Asians (4%). Obviously, harassment and physical attacks have a deterrent effect on patients seeking additional care and impact the wider community as information about such abuses circulates.

Outness

In accordance with professional standards, doctors can provide more effective care when they have all medically relevant information about their patients. Unfortunately, our data shows that doctors' knowledge of a patient's transgender status increases the likelihood of discrimination and abuse. Medical professionals' awareness of their patient's transgender status ***increased experiences of discrimination*** among study participants up to eight percentage points depending on the setting:

28%
reported being verbally harassed in a medical setting

- **Denied service altogether:** 23% of those who were out or mostly out to medical providers compared to 15% of those who were not out or partly out
- **Harassment in ambulance or by EMT**: 8% of those who were out or mostly out to medical providers compared with 5% of those who were not out or partly out
- **Physically attacked or assaulted in a hospital**: 2% of those who were out or mostly out to medical providers compared with 1% of those who were not out or partly out

Medical Providers' Lack of Knowledge

When respondents saw medical providers, including doctors, they often encountered ignorance about basic tenets of transgender health and found themselves required to "teach my provider" to obtain appropriate care. Fully 50% of study respondents reported having to teach providers about some aspect of their health needs; those who reported "teaching" most often include female-to-male transgender respondents (61%), those who live full-time as their gender identity (61%), and those on public insurance (56%).

Postponement of Necessary and Preventive Medical Care

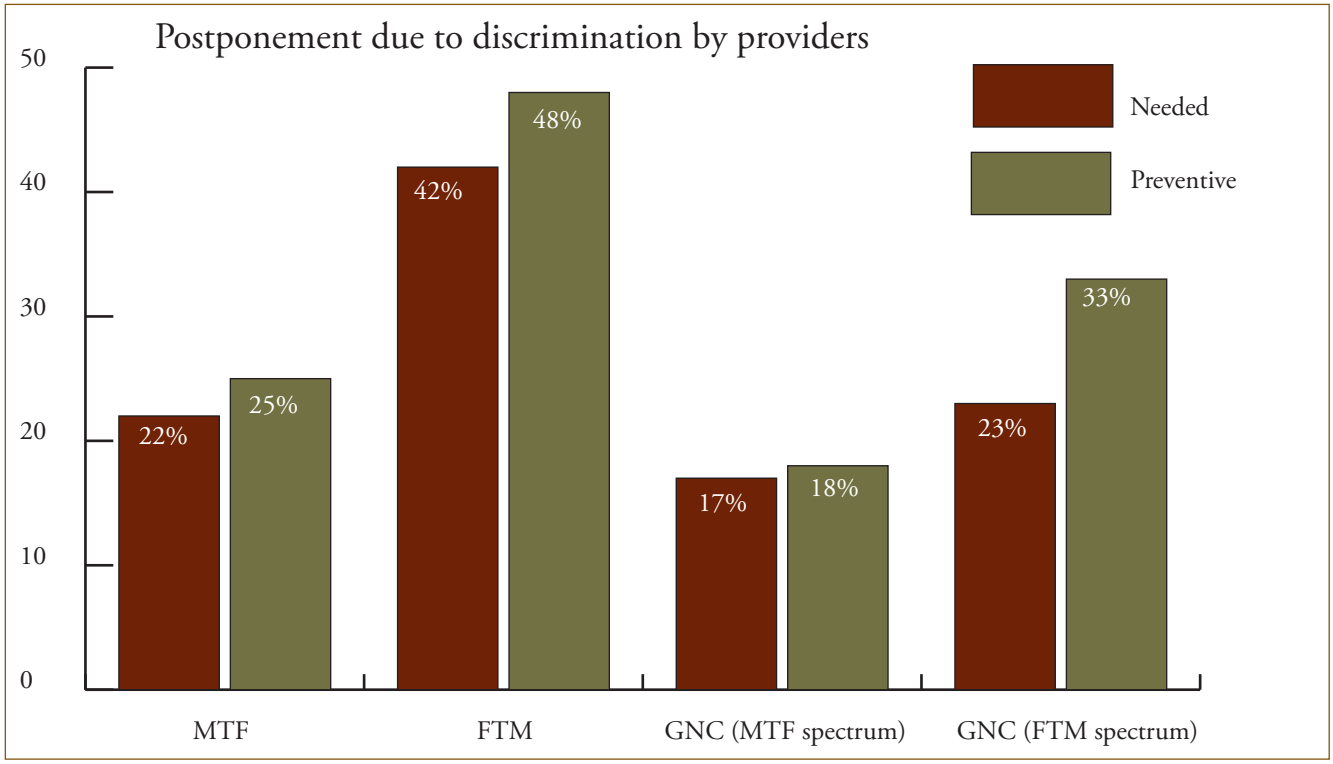
We asked respondents whether they postponed or did not try to get two types of health care: preventive care "like checkups" and necessary care "when sick or injured." We found that many postponed care because they ***could not afford it*** and many postponed care because of ***discrimination and disrespect from providers***.

One fourth of study participants report delaying needed care because of disrespect and discrimination from medical providers.

A significant number of study participants postponed necessary medical care due to inability to afford it, whether seeking care when sick or injured (48%), or pursuing preventive care (50%). Female-to-male transgender respondents report postponing any care due to inability to afford it at higher rates (55%) than male-to-female transgender respondents (45%).

Insurance played a significant factor: those who have private insurance were much less likely to postpone care because of inability to afford it when sick or injured (37%) than those with public (46%) or no insurance who postponed care (86%).

In terms of preventive care, those without insurance reported delaying care due to inability to afford it much more frequently (88%) than those with private insurance (39%) or public insurance (44%). Failing to obtain preventive care is known to lead to poor long-term health outcomes.



Due to discrimination and disrespect, 28% postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not try to get preventive health care. Female-to-male transgender respondents reported postponing care due to discrimination and disrespect at a much higher frequency (42%, sick/injured; 48% preventive) than male-to-female transgender respondents (22%, sick/injured; 25% preventive). Those with the highest rates of postponement included those who have lost a job due to bias (45%) and those who have done sex work, sold drugs, or engaged in other underground economies for income (45%). Twenty-nine percent (29%) of respondents who were "out" or "mostly out" to medical providers reported they had delayed care when ill and 33% postponed or avoided preventive care because of discrimination by providers.

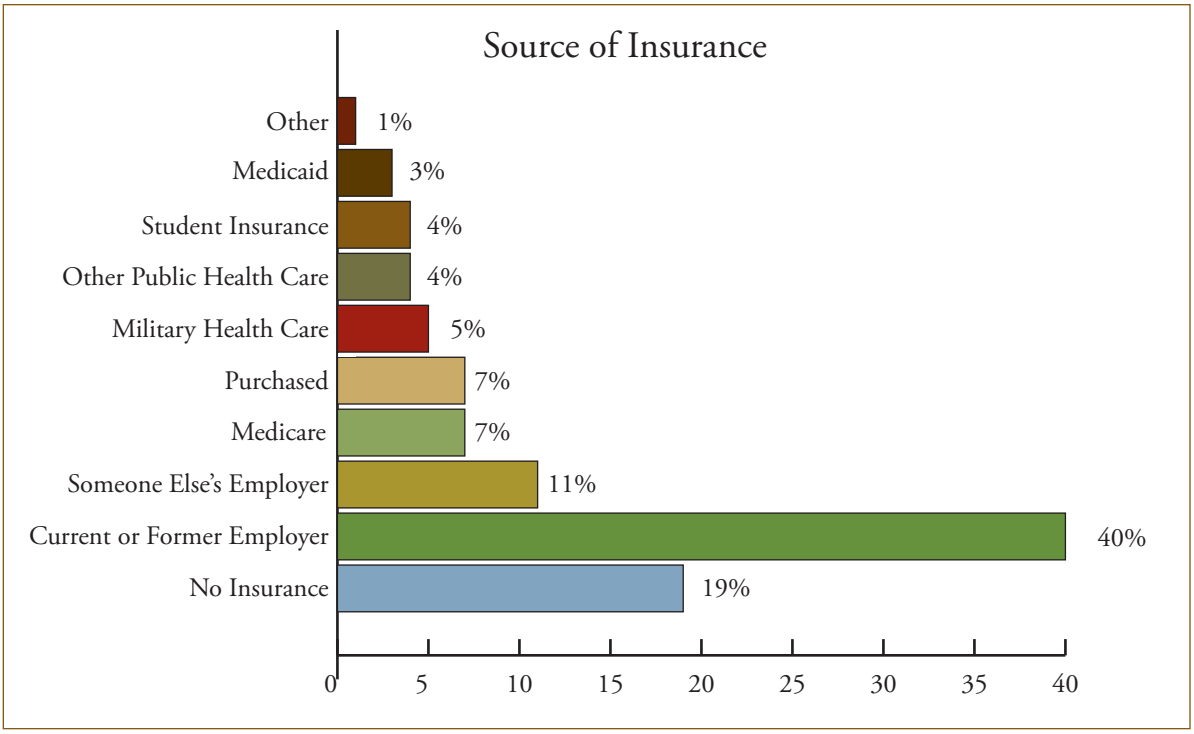
Access to Insurance

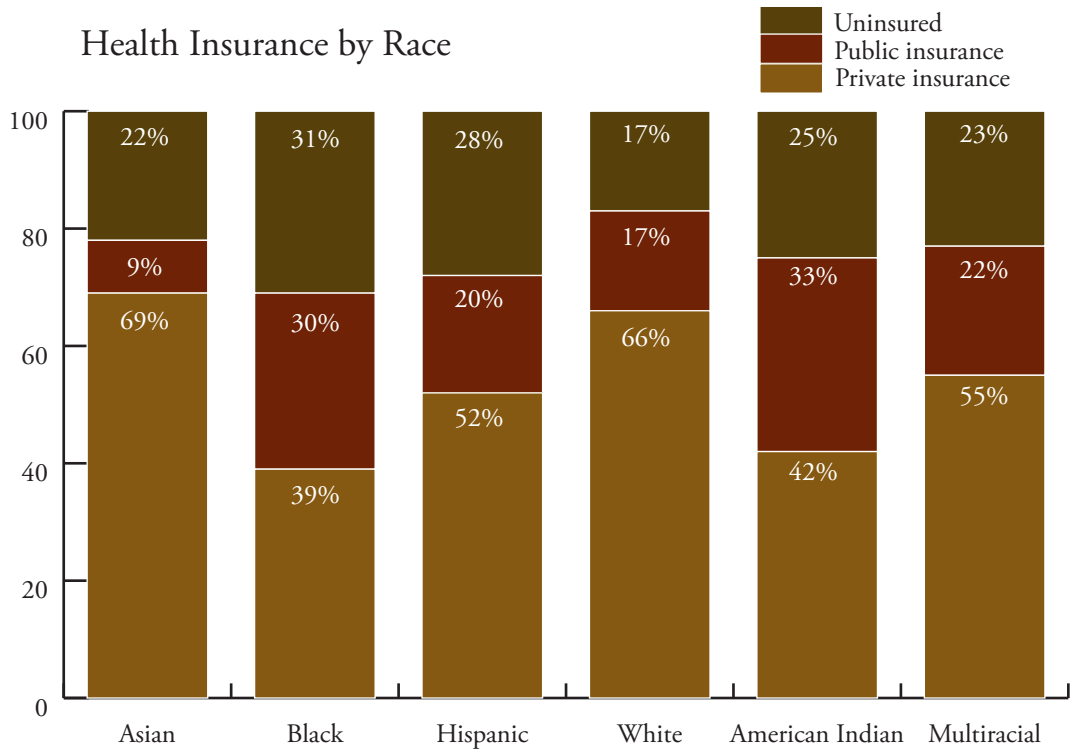
Study participants were less likely than the general population to have health insurance, more likely to be covered by state programs such as Medicare or Medicaid, and less likely to be insured by an employer.

Nineteen percent (19%) of the sample lacked any health insurance compared to 15% of the general population.[5]

African-American respondents had the worst health insurance coverage of any racial category: 39% reported private coverage and 30% public. Thirty-one percent (31%) of Black respondents reported being uninsured; by contrast 66% of white respondents reported private insurance, 17% public insurance and 17% uninsured.

Undocumented non-citizens had very low rates of coverage: 26% reported private insurance, 37% public insurance, and 36% no insurance. The South was the worst region for coverage where 59% of respondents reported private insurance, 17% public insurance and 25% no insurance. In terms of gender, MTFs reported private insurance at 56%, public insurance at 23% and 20% uninsured. FTMs reported private insurance at 69%, public insurance at 13% and 19% with no insurance. Gender non-conforming respondents were insured at higher rates than their transgender counterparts, with 73% private insurance, 11% public insurance, and 17% uninsured.




Health Insurance by Race
Uninsured
Public insurance
Private insurance
100
80
60
40
20
0
22%
9%
69%
31%
30%
39%
28%
20%
52%
17%
17%
66%
25%
33%
42%
23%
22%
55%
Asian
Black
Hispanic
White
American Indian
Multiracial

TRANSITION-RELATED CARE

Most survey respondents had sought or accessed some form of transition-related care. Counseling and hormone treatment were notably more utilized than any surgical procedures, although the majority reported wanting to "someday" be able to have surgery. The high costs of gender-related surgeries and their exclusion from most health insurance plans render these life-changing (in some cases, life-saving) and medically necessary procedures inaccessible to most transgender people.

Throughout this section, we focus primarily on transgender people rather than on gender non-conforming people. Gender non-conforming people may also desire and sometimes acquire various forms of gender-related medical care.

The World Professional Association for Transgender Health (WPATH) publishes Standards of Care[6] which are guidelines for mental health, medical, and surgical professionals on the current consensus for providing assistance to patients who seek transition-related care. They are intended to be flexible to assist professionals and their patients in determining what is appropriate for each individual. The Standards of Care are a useful resource in understanding the commonly experienced pathways through transition-related care.

Counseling

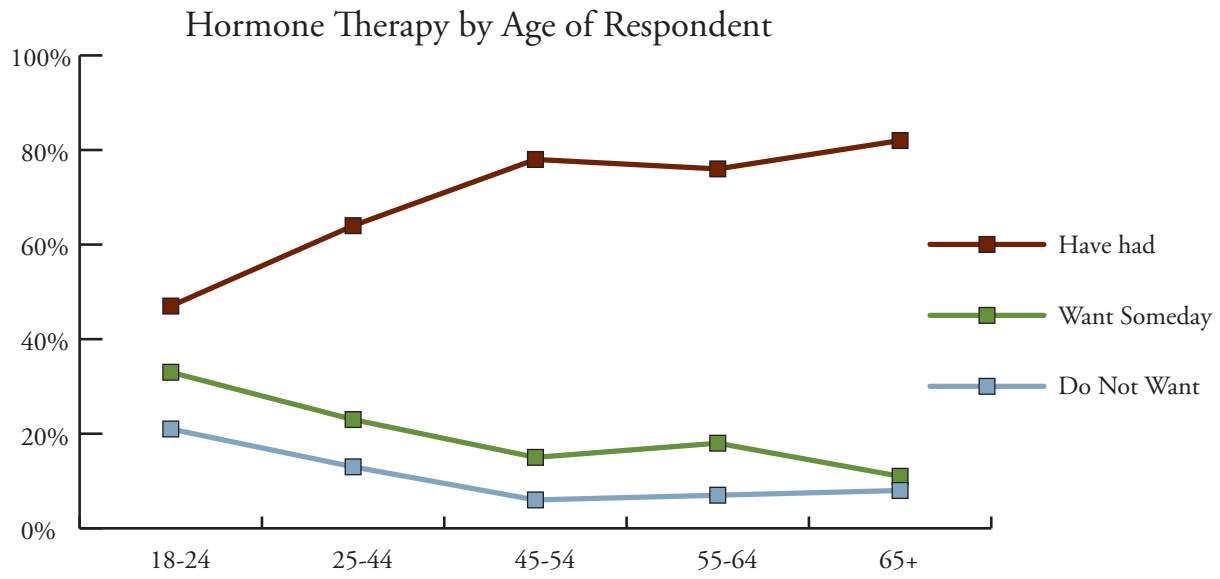
Counseling often plays an important role in transition. Because of the WPATH Standards of Care, medical providers often require a letter from a qualified counselor stating that the patient is ready for transition-related medical care; transgender people may seek out counseling for that purpose. Counseling may also play a role in assisting with the social aspects of transition, especially in dealing with discrimination and family rejection.

Seventy-five percent (75%) of respondents received counseling related to their gender identity and an additional 14% hoped to receive it someday. Only 11% of the overall sample did not want it. Those who identified as transgender were significantly more likely to have had counseling (80%) than those who are gender non-conforming (48%). Eighty-nine percent (89%) of those who medically transitioned have received counseling along with 91% of those who had some type of surgery.

Part of counseling can involve receiving a gender-related mental health diagnosis such as "Gender Identity Disorder." Many doctors require this diagnosis before providing hormones or surgical treatment, but the diagnosis itself is widely criticized as pathologizing naturally occurring gender variance.[7] Fifty-percent (50%) of study participants have received a gender-related mental health diagnosis. MTFs reported a higher rate of diagnosis (61%) than FTMs (53%); and transgender-identified participants had a significantly higher rate of diagnosis (58%) than gender non-conforming respondents (11%).

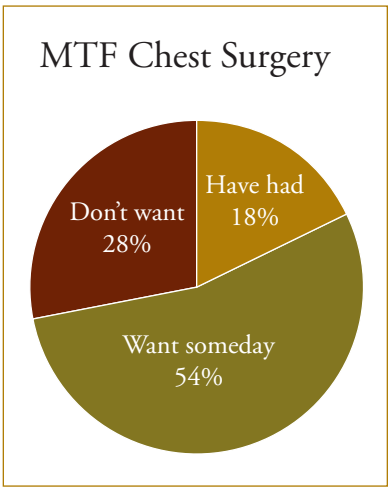
Hormone Therapy

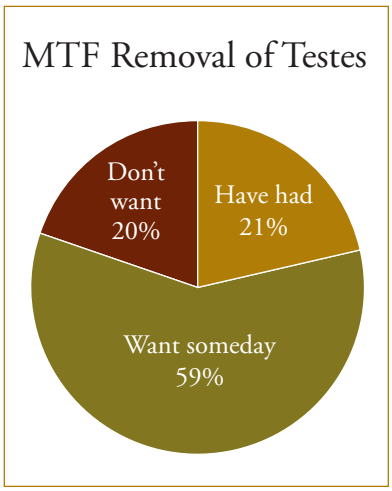
Sixty-two percent (62%) of respondents have had hormone therapy, with the likelihood increasing with age; an additional 23% hope to have it in the future. Transgender-identified respondents accessed hormonal therapy at much higher rates than their gender non-conforming peers, with those who identified as MTF more likely to have accessed hormone therapy (71%) than FTM respondents (66%). Almost all respondents who reported undertaking transition-related surgeries also reported receiving hormone therapy (93%).

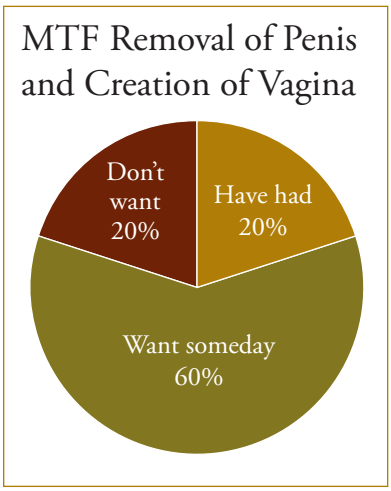


Surgery—Male-to-female

Transgender women may elect to undertake a variety of surgeries, including breast augmentation, removal of testes, other genital surgeries, and facial feminization surgery. We asked respondents to report on chest surgery, removal of the testes, and other genital surgery. Three-quarters of transgender women reported that they desired to have surgery at some point in the future or had already done so. However, it is impossible to know how many would desire or utilize surgery if it were more financially accessible.

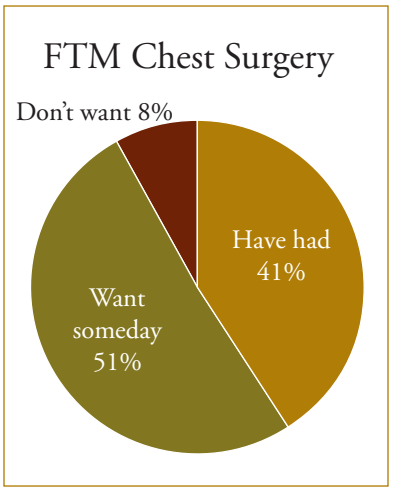


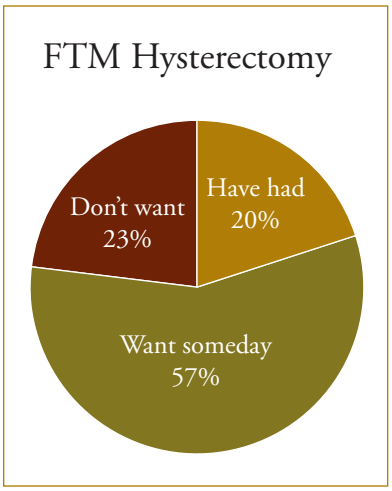


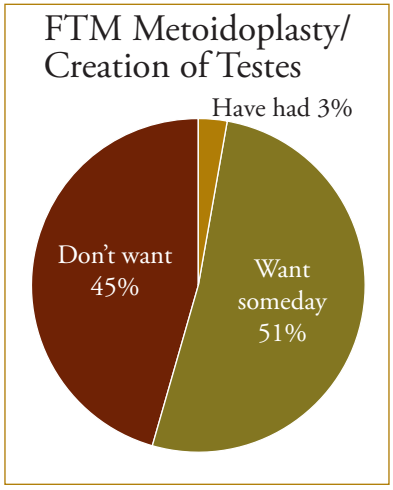


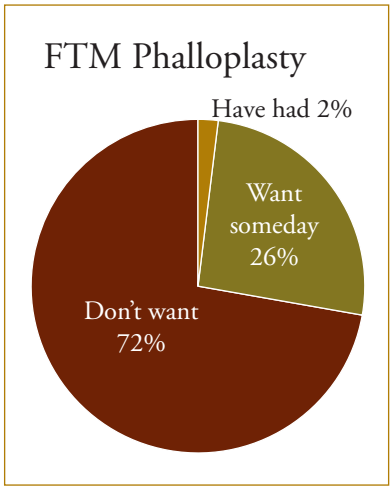
Surgery—Female-to-male

Transgender men may elect to undertake a variety of surgeries, including chest reconstruction, hysterectomy and other genital surgeries. We asked respondents to report on chest surgery; hysterectomy; metoidioplasty, which releases the clitoris; surgeries that create testes; and phalloplasty, which surgically creates a penis and testes. The majority of FTM transgender-identified respondents wanted to have, or have already had, chest surgery and a hysterectomy. However, when it came to genital surgeries, very few reported having such surgeries; a slim majority (51%) reported desiring other genital surgery such as metoidoplasty in addition to the 3% that have had it; and one-quarter (26%) wanted to have a phalloplasty in addition to the 2% who have had it. It is impossible to know how these rates would change if these surgeries were financially accessible.







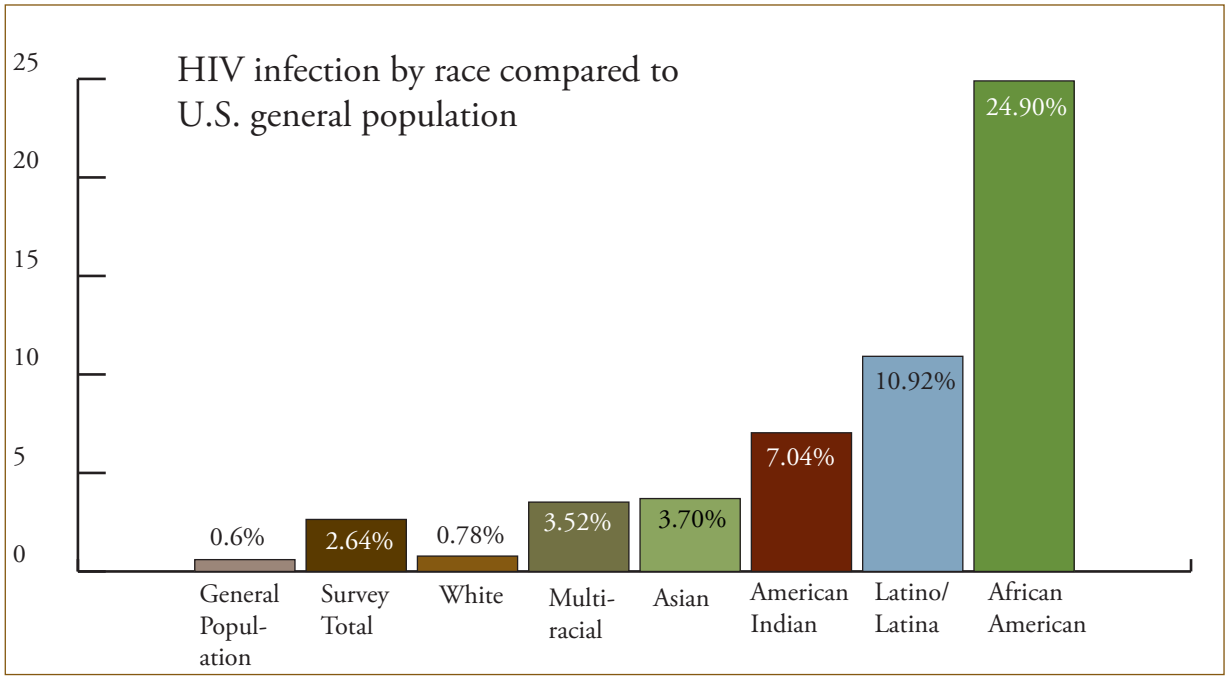


HEALTH VULNERABILITIES

Survey participants reported poorer health outcomes than the general population in a variety of critical health areas.

HIV

Respondents reported an HIV infection rate of 2.64%, over four times the rate of HIV infection in the general United States adult population (0.6%) as reported by the United Nations Programme on HIV/AIDS and the World Health Organization.[8] People of color reported HIV infection at significantly higher rates: 24.90% of African-Americans, 10.92% of Latino/as, 7.04% of American Indians, and 3.70% of Asian-Americans in the study reported being HIV positive. This compares with national rates of 2.4% for African Americans, .08% Latino/as, and .01% Asian Americans.[9] Non-U.S. citizens in our sample reported more than twice the rate of HIV infection of U.S. citizens (2.41%), with documented non-citizens at 7.84% and undocumented at 6.96%.



Engaging in sex work for income clearly was a major risk factor for study participants, with 61% of those who reported HIV infection in our sample having engaged in sex work. To consider this from a different angle, of all the people in our sample who had engaged in sex work, 15.32% reported being HIV positive.

Among survey participants, 91% of those who reported being HIV positive identified as either MTF or gender non-conforming on the male-to-female spectrum. The reported rate of HIV infection for the MTF transgender respondents was 3.76%. The reported rate of HIV infection for FTM respondents was .48%, lower than the national average.

Other categories that reported significantly higher HIV rates than the sample as a whole were:

- Those without a high-school diploma (13.49%)
- Those with income below $10,000 a year (6.40%)
- Those who had lost a job due to bias (4.59%) or reported being unemployed (4.67%)

Eight percent (8%) of our sample reported that they did not know their HIV status.

Drug and Alcohol Use

The National Institutes of Health (NIH) estimate that 7.3% of the general public abuses or is dependent on alcohol, while 1.7% abuses or is dependent on non-prescription drugs.[10] Eight percent (8%) of study participants reported currently using alcohol or drugs specifically to cope with the mistreatment that they received as a result of being transgender or gender non-conforming, while 18% said they had done so in the past but do not currently. We did not ask about general use of alcohol and drugs, only usage which the respondents described as a coping strategy for dealing with the mistreatment they face as a transgender or gender non-conforming person.

26% use or have used alcohol and drugs to cope with the impacts of discrimination.

Participation in sex work, drug sales, and other underground economies for income more than doubles the risk of alcohol or drug use because of mistreatment, with 19% of these respondents currently using alcohol and/or drugs while 36% reported that they had done so in the past. Also at elevated risk were those who had lost a job due to discrimination; 12% reported currently using drugs and alcohol, while 28% have done so in the past.

Alcohol and drug use decreased by age among our participants, the same as in studies of the general population,[11] with those 65 years and above reporting less than half the rate of use (4%) of those who are the 18-44 age range (9%). This contrasts with studies of LGBT populations that show a less dramatic decrease in use over the life cycle;[12] however, because our study only asked about use connected to mistreatment, the comparisons with both the general population and LGBT studies are not exact.

Smoking

Thirty percent (30%) of our sample reported smoking daily or occasionally, compared to 20.6% of U.S. adults.[13] Studies of LGBT adults show similar rates to our study, with elevated rates of 1.1-2.4 times that of the general population,[14] and a 2004 California study found a 30.7% smoking rate for transgender people.[15] In the general population, men smoke at higher rates than women, but in LGBT studies, women smoke at higher rates than men. Our sample resembled the LGBT data regarding elevated smoking levels but differed in that more men than women in our sample smoke, a pattern which is closer to that of the general population. When asked if they would "like to quit," 70% of smokers in the study selected yes.

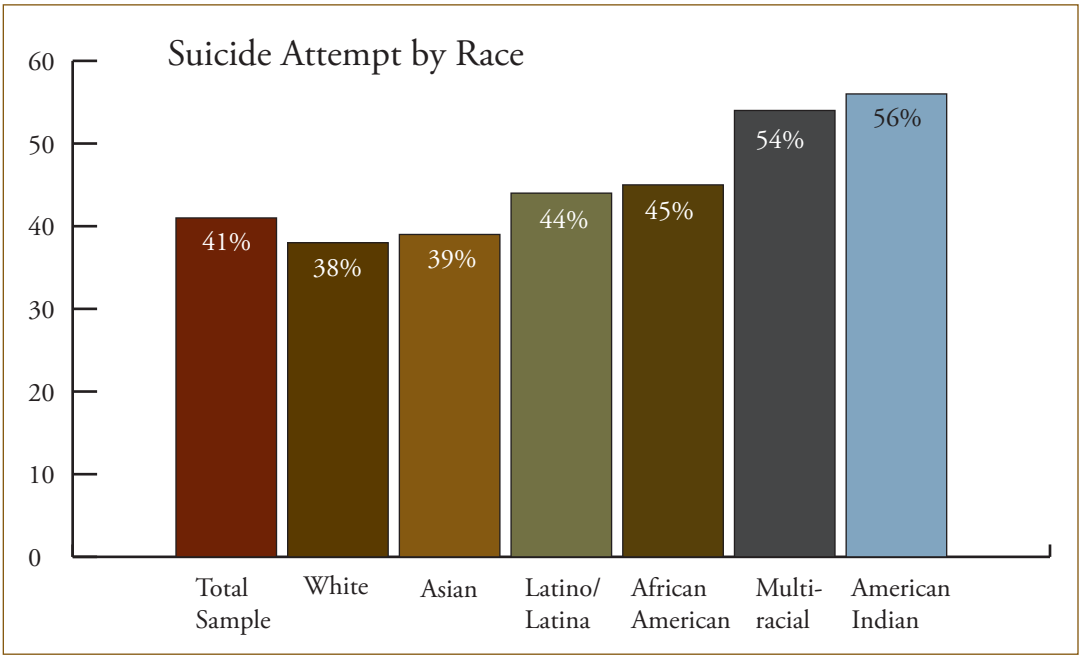
Comparisons[16]	General Population	Lesbian and Gay	Bisexual	Our Sample
Men	23.1%	26.5-30.9%	29.5-38.1%	33%
Women	18.3%	22.3-26%	30.9-39.1%	29%

Suicide Attempts

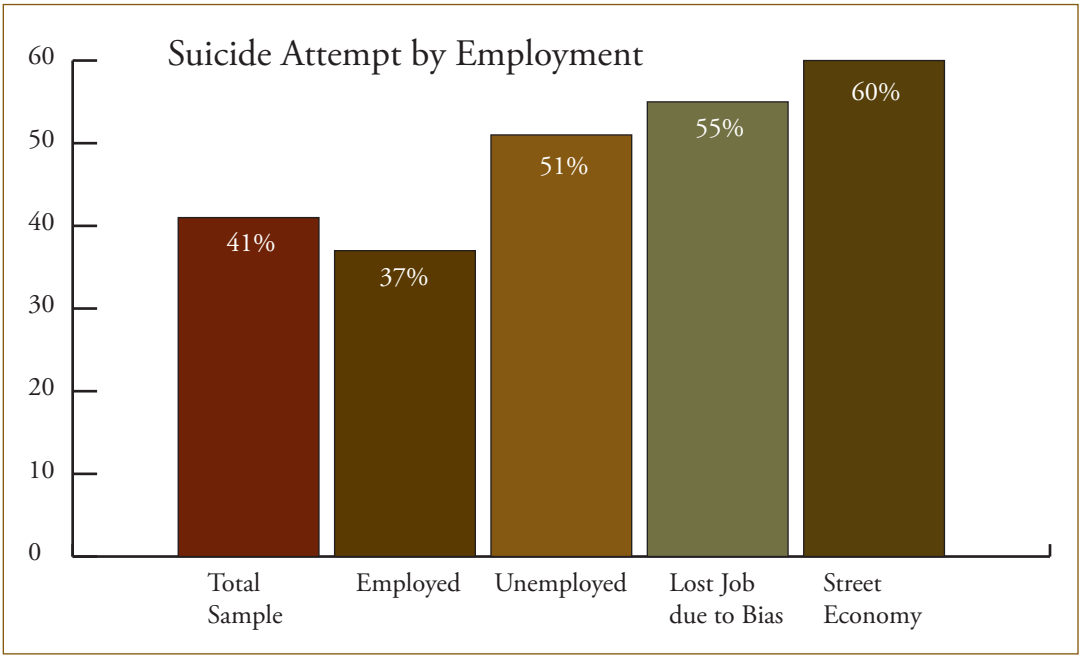
When asked "have you ever attempted suicide?" 41% of respondents answered yes. According to government health estimates, five million, or 1.6%, of currently living Americans have attempted suicide in the course of their lives.[17] Our study asked if respondents had ever attempted suicide while most federal studies refer to suicide attempts within the last year; accordingly it is difficult to compare our numbers with other studies. Regardless, our findings show a shockingly high rate of suicidality.

The National Institute for Mental Health (NIMH) reports that most suicide attempts are signs of extreme distress, with risk factors including precipitating events such as job loss, economic crises, and loss of functioning.[18] Given that respondents in this study reported loss in nearly every major life area, from employment to housing to family life, the suicide statistics reported here cry out for further research on the connection between the consequences of bias in the lives of transgender and gender non-conforming people and suicide attempts.[19]

NIMH also reports that generally African-Americans, Hispanics and Asians have significantly lower suicide rates than whites and American Indians; our sample showed a different pattern of risk for suicide by race.



Respondents' work status had a significant impact on their likelihood of having attempted suicide:



In terms of age cohort risk, the highest rates of suicide attempts in this study were reported among those in the 18-44 age cohort (45%), with only 16% of those over 65 reporting a suicide attempt. These rates are inverse to the general population, which shows a higher incidence of attempts among older Americans than youth.

Our data does not show at what age the respondents made suicide attempts and therefore it is difficult to draw conclusions about the risk of suicide over their life spans. However, there are a number of attributes that correlate with an increased rate of attempted suicide. High risk cohorts include visual non-conformers (44%); those who are generally out about their transgender status (44%); and those who have only some of their identity documents in

their preferred gender (46%). Those who have medically transitioned (45%) and surgically transitioned (43%) have higher rates of attempted suicide than those who have not (34% and 39% respectively).

Those who were bullied, harassed, assaulted, or expelled because they were transgender or gender non-conforming in school also reported significantly elevated levels of suicide attempts (51% compared with 41% of our sample as a whole). Most notably, suicide attempt rates rise dramatically when teachers were the reported perpetrators: 59% for those harassed or bullied by teachers, 76% among those who were physically assaulted by teachers and 69% among those who were sexually assaulted by teachers. These numbers speak to the urgency of ending violence and harassment of transgender students by both their peers and their teachers.

Education and income both correlate with suicide rates, with those earning $10,000 annually or less at extremely high risk (54%), while those making more than $100,000 are at comparatively lower risk (26%), while still astronomically higher than the general population. Those who have not completed college attempted suicide at higher rates (48% among those with no high school degree, 49% for those with a high school degree only, and 48% for those with some college education) while those have completed college (33%) or graduate school (31%) have significantly lower rates.

Those who had survived violence perpetrated against them because they were transgender or gender non-conforming were at very high risk; 61% of physical assault survivors reported a suicide attempt, while sexual assault survivors reported an attempt rate of 65%.

CONCLUSION AND RECOMMENDATIONS

Respondents in our study reported significant barriers to health care and outrageous frequencies of anti-transgender bias in care, from disrespect to refusal of care, from verbal harassment to physical and sexual abuse. Transgender people of color and low income respondents faced significantly elevated risk of abuse, refusal of care, and poor health outcomes than the sample as a whole.

The data gathered here speak to a tremendous need to examine the connection between multiple incidences of discrimination, harassment, and abuse faced by our respondents in the health care system and the high risk for poor health outcomes. Additionally, our data suggest that discriminatory events are commonplace in the daily lives of transgender people and that this has a cumulative impact—from losing a job because of bias to losing health insurance; from experiencing health provider abuse to avoiding health care; from long-term unemployment to turning to work on the streets. The collective impact of these events exposed our respondents to increased risk for HIV infection, smoking, drug/alcohol use, and suicide attempts.

It is important to note that the traumatic impact of discrimination also has health care implications. Transgender people face violence in daily life, compounded by the high rates of physical and sexual assault that transgender people face while accessing medical care, which leads to additional health care costs, both to treat the immediate trauma as well as ongoing physical and psychological issues that may be created.

As we have seen across a number of categories in the survey, the ability to work significantly impacts transgender health. In particular, those who have been fired due to anti-transgender bias and those who have engaged in sex work, drug sales, or other underground economies for income are much more likely to experience health risks that are shown to lead to poorer health outcomes.

Discrimination in the health care system presents major barriers to care for transgender people and yet a majority of our survey participants were able to access some transition-related care, with 75% receiving counseling and 62% obtaining hormones. Genital surgery, on the other hand, remains out of reach for a large majority, despite being desired by most respondents. This is one significant reason why legal rights for transgender people must never be determined by surgical status.

Recommendations

- Anti-transgender bias in the medical profession and U.S. health care system has catastrophic consequences for transgender and gender non-conforming people. This study is a call to action for the medical profession;
  - The medical establishment must fully integrate transgender-sensitive care into its professional standards, and this must be part of a broader commitment to cultural competency around race, class, and age;
  - Doctors and other health care providers who harass, assault, or discriminate against transgender and gender non-conforming patients should be disciplined and held accountable according to the standards of their professions.

- Public and private insurance systems must cover transgender-related care; it is urgently needed and is essential to basic health care for transgender people.

- Ending violence against transgender people must be a public health priority, because of the direct and indirect negative effect it has on both victims and on the health care system that must treat them.

- Medical providers and policy makers should never base equal and respectful treatment and the attainment of government-issued identity documents on:
  - Whether an individual has obtained surgery, given that surgeries are financially inaccessible for large majorities of transgender people because they are rarely covered by either public or private insurance;
  - Whether an individual is able to afford or attain proof of citizenship or legal residency.

- Rates of HIV infection, attempted suicide, drug and alcohol abuse, and smoking among transgender and gender non-conforming people speak to the overwhelming need for:
  - Transgender-sensitive health education, health care, and recovery programs;
  - Transgender-specific prevention programs.

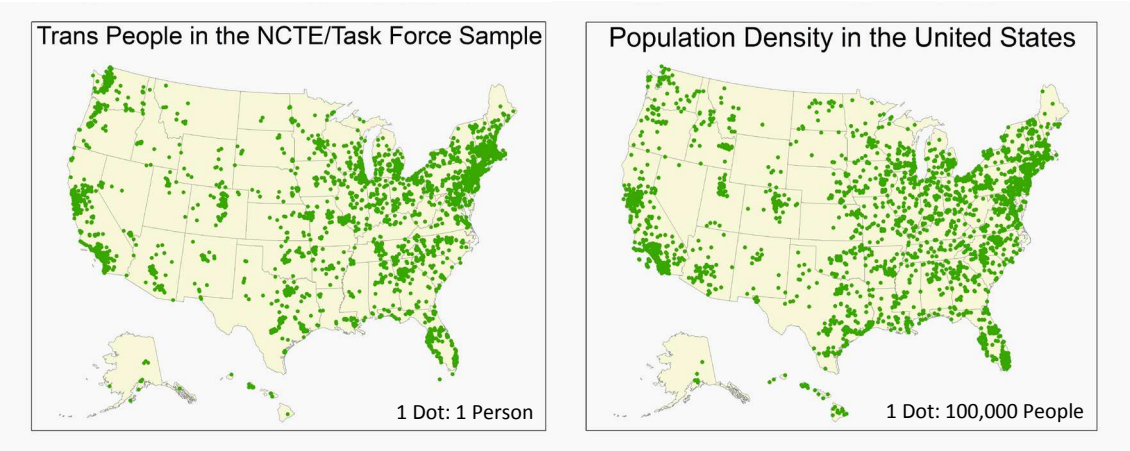
- Additional data about the health outcomes of transgender and gender non-conforming people is urgently needed;
  - Health studies and other surveys need to include transgender as a demographic category;
  - Information about health risks, outcomes and needs must be sought specifically about transgender populations;
  - Transgender people should not be put in categories such as "men who have sex with men" (MSM) as transgender women consistently are and transgender men sometimes are. Separate categories should be created for transgender women and transgender men so HIV rates and other sexual health issues can be accurately tracked and researched.

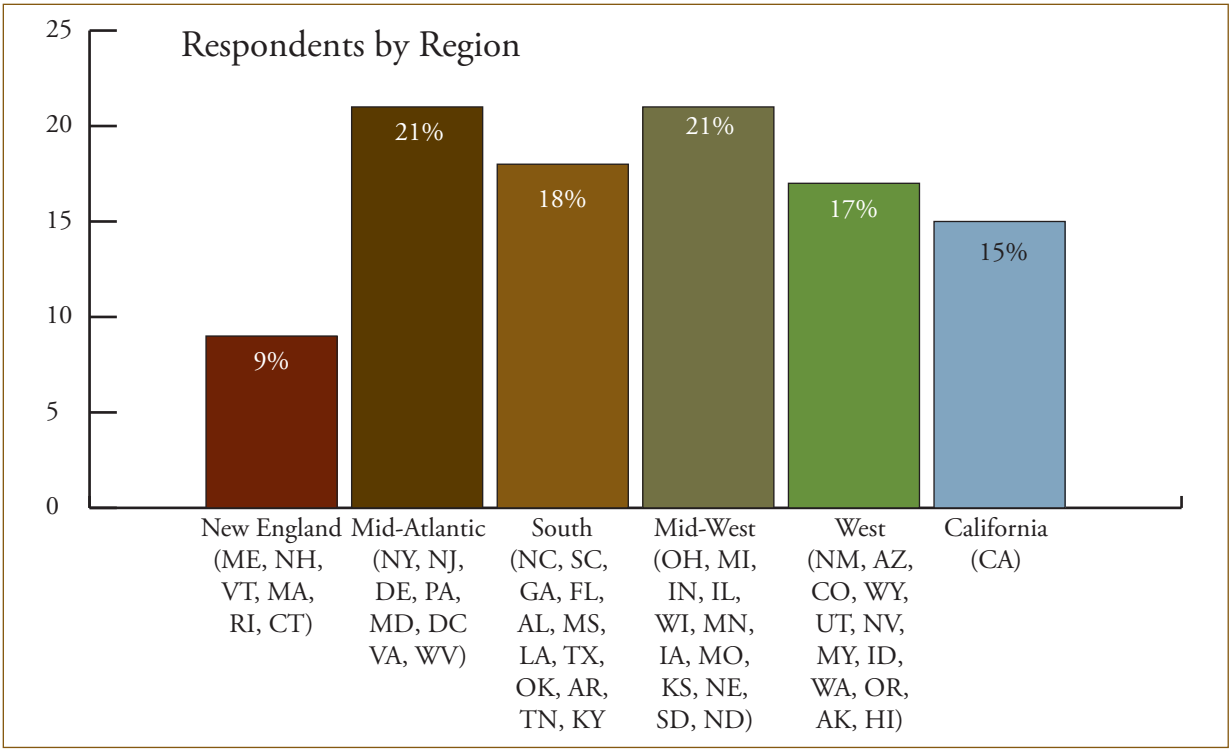
METHODOLOGY

The National Transgender Discrimination Survey is the most extensive survey of transgender discrimination ever undertaken. Over four months, our research team fielded its 70 question survey through direct contacts with more than 800 transgender-led or transgender-serving community-based organizations throughout the United States. We also contacted possible participants through 150 active online community listservs. The vast majority of respondents took the survey on-line, through a URL established at Pennsylvania State University.[21]

Additionally, we distributed 2,000 paper surveys to organizations serving hard-to-reach populations – including rural, homeless, and low-income transgender and gender non-conforming people –conducting phone follow-ups over three months. With only $3,000 in dedicated funding for outreach, we paid stipends to workers in homeless shelters, legal aid clinics, mobile health clinics, and other service settings to host "survey parties" to encourage respondents whose economic vulnerability, housing insecurity, or literacy level might pose particular barriers to participation. This effort resulted in the inclusion of 500 paper surveys in the final sample.[22]

While over 7,000 people completed online and paper surveys, the final study sample includes 6,450 valid respondents from all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. Our geographic distribution mirrors that of the general U.S. population.





Demographics.

We asked participants questions to help us create categories by which we could consider their reported experiences. Any attempt to create such constructs is limited and constraining. We did so in the interest of analyzing conditions and situations that are more harmful or less harmful and more empowering or more threatening to the well-being of our respondents.[23]

Gender Identity

Respondents identified across a broad spectrum of gender identities.

We asked several questions to establish the gender identity of our respondents, including: sex assigned at birth; current gender identity; and a list of terms that describe various gender identities including MTF, FTM, genderqueer, androgynous, two-spirited, etc. We asked respondents to indicate where they rested along a spectrum of identification with the many terms on our list, from "strongly" to "not at all." From this set of responses, we created criteria for several gender categories that, though limited, provide a framework from which to analyze strengths, resiliencies, and exposure to prejudice and abuse.

In this report on health, we generally commented on the experiences of respondents who—via the choices described above—identify as male-to-female transgender (MTF), also referred to as transgender women, and female-to-male transgender (FTM), also referred to as transgender men. Fully 88% of all respondents fall into one of these two categories.

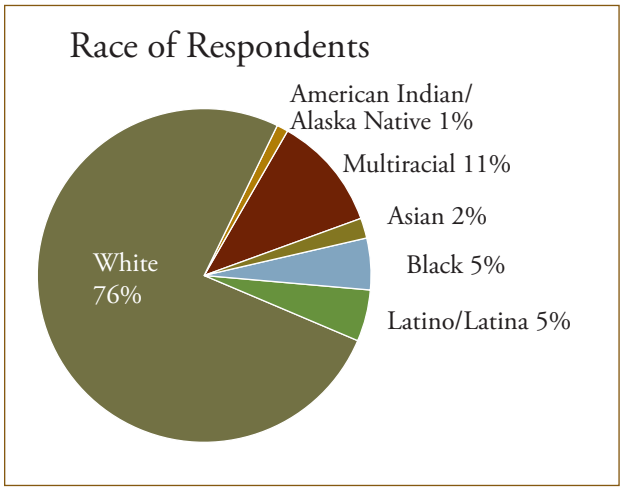
We also discussed the experiences of the 12% of the sample to whom we refer as "gender non-conforming," which includes those who identified as gender queer or as gender non-conforming. Three percent (3%) of our sample self-reported identifying as gender non-conforming along a male-to female spectrum of gender identity and 9% describe themselves as gender non-conforming along a female-to-male spectrum of gender identity.

While the research team understands gender identity and expression to be more complex and layered than the collapsed categories presented here, for the purposes of this study, these constructs created useful "containers" in which to organize and analyze respondents' experiences of anti-transgender bias and its impacts.

Race

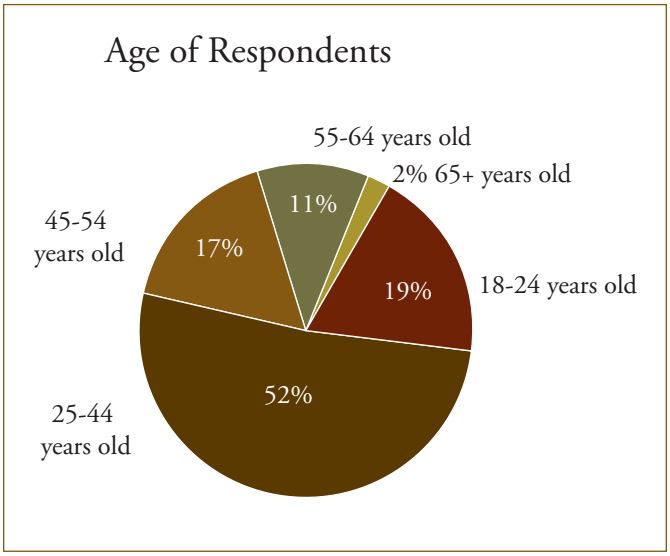
Along the same lines as our questions on gender, the research team used standard but simplified racial categories for the purposes of analysis and to avoid statistically insignificant sample sizes. The persistence of racism in the U.S. creates observable negative outcomes in terms of present-day realities for our transgender respondents. Our findings confirm what is obvious in American society today: structural racism—and its significant consequences—persists.

With a "check all that apply" instruction, respondents chose from a limited list of race signifiers. While our choices do not mirror Census demographic categories on race, which are more extensive, our sample's racial and ethnic breakdown resembles the national portrait of race and ethnicity.



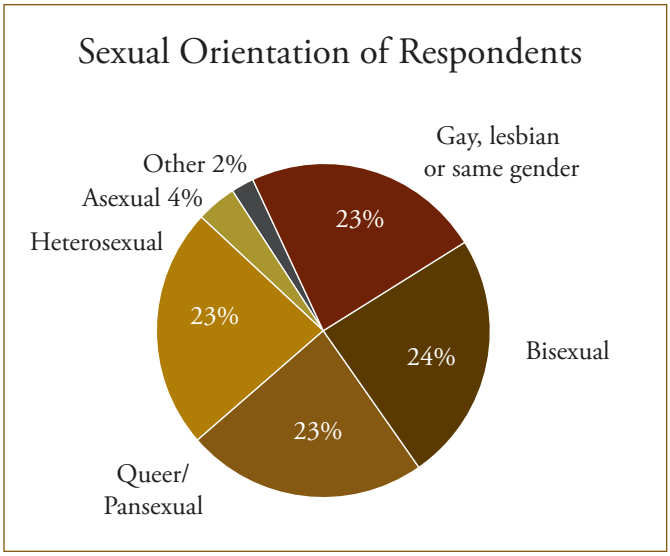
Age

The sample includes participants from 18 to 89 years of age. In nearly every age category, this is the largest sample of transgender experiences of discrimination ever collected.



Sexual Orientation

The sexual orientation of the sample demonstrates the diverse spectrum of sexual orientations among transgender and gender non-conforming people. Among respondents, 23% reported a lesbian, gay, or same-gender attracted sexual orientation; 24% identified as bisexual; 23% reported a queer/pansexual orientation; 23% reported a heterosexual sexual orientation; 4% describe themselves as asexual; and 2% wrote in other answers.



This chart illustrates the range of sexual orientations in the transgender community. Those who assume all transgender people are straight after transition are as incorrect as those who would assume them all to be gay, lesbian, or bisexual. These assumptions create additional barriers even in supposedly transgender-friendly spaces.

The common assumption that gender identity and sexual orientation form the basis for two distinct communities obscures the reality, documented here, that the majority of transgender people are lesbian, gay, bisexual, or queer-identified. While debate in the LGBT community often draws clear lines of demarcation between the LGBs and the Ts, our findings suggest that there is significant overlap.

ENDNOTES

[1]Some researchers have found that coming out to family members and others may have some positive influence on identity formation and social and intimate relationships for lesbians and gay men. Savin-Williams, R. (1989). "Coming Out to Parents and Self-Esteem Among Gay and Lesbian Youths," *Journal of Homosexuality* 18(1-2); Meyer, Ilan. (2003). "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence," *Psychol Bull* 129(5); Eliason, M. (1996). "Identity Formation for Lesbian, Bisexual, and Gay Persons," *Journal of Homosexuality* 30(3).

[2]See for example Foraselli, P., DeAngelis, C., & Kaszuba, A. (1985). Compliance with follow-up appointments generated in a pediatric emergency room. *Am J Prev Med*, 1(3), *Pediatr Emerg Care*. Chande, V.T., Krug, S.E., & Warm, E.F. (1996). Pediatric emergency department utilization habits: a consumer survey. *Pediatr Emerg Care,* 12(1).

[3]These results were based on our question 30, which was prefaced by: "Based on being transgender/gender non-conforming, please check whether you have experienced any of the following in these public spaces," and asked respondents to indicate whether they had been "denied equal treatment or service" for each of the various locations.

[4]These results were based on our question 43, which was prefaced by: "Because you are transgender/gender non-conforming, have you had any of the following experiences?" and asked respondents to indicate whether "a doctor or other provider refused to treat me because I am transgender/gender nonconforming."

[5]DeNavas-Walt, C., Proctor, B., Smith, J., & U.S. Census Bureau. (2009). Current Population Reports, Income, Poverty, and Health Insurance Coverage in the United States: 2008. Retrieved September 22, 2010, from http://www.census.gov/prod/2009pubs/p60-236.pdf

[6]World Professional Association of Transgender Health. (2001). Standards of Care for Gender Identity Disorders, Sixth Version. Retrieved September 21, 2010, from http://www.wpath.org/documents2/socv6.pdf

[7]The National Gay and Lesbian Task Force's statement on reform of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) can be accessed at http://www.transgenderlaw.org/medicalhealthcare/NGLTF_DSM_Statement.pdf . The National Center for Transgender Equality's position may be found at http://transgenderequality.wordpress.com/wp-admin/post.php?post=264&action=edit .

[8]United Nations Programme on HIV/AIDS (UNAIDS), & World Health Organization (WHO). (2007). 07 AIDS Epidemic Update. Retrieved September 14, 2010, from http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

[9]Henry J. Kaiser Family Foundation. (2007). The HIV-AIDS Epidemic in the United States. Retrieved September 14, 2010, from http://www.kff.org/hivaids/upload/3029-071.pdf

[10]Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health: National Findings. Retrieved September, 14, 2010, from http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.pdf

[11]Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings. Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586Findings. In particular, see p. 30, chart 3.1.

[12]National Institute on Alcohol and Alcoholism. (2005). Sexual Orientation and Alcohol Use Disorders. Retrieved September 24, 2010, from http://pubs.niaaa.nih.gov/publications/social/Module10GSexualOrientation/Module10G.html.

[13]American Lung Association. (2010). Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community. Retrieved September 14, 2010, from http://www.lungusa.org/assets/documents/publications/lung-disease-data/lgbt-report.pdf

[14]Review of literature aggregated in American Lung Association. (2010). Smoking Out A Deadly Threat: Tobacco Use in the LGBT Community. Retrieved September 14, 2010, from http://www.lungusa.org/assets/documents/publications/lung-disease-data/lgbt-report.pdf.

[15]Bye, L., Gruskin, E., Greenwood, G., Albright, V., & Krotki, K. (2005). California Lesbians, Gays, Bisexuals, and Transgender (LGBT) Tobacco Use Survey – 2004. California Department of Health Services. Retrieved September 14, 2010, from http://www.cdph.ca.gov/programs/tobacco/Documents/CTCP-LGBTTobaccoStudy.pdf

[16]The general population, lesbian and gay, and bisexual data in this table is from Bye, L., Gruskin, E., Greenwood, G., Albright, V.,& Krotki, K. (2005). California Lesbians, Gays, Bisexuals, and Transgender (LGBT) Tobacco Use Survey – 2004. California Department of Health Services. Retrieved September 14, 2010, from http://www.cdph.ca.gov/programs/tobacco/Documents/CTCP-LGBTTobaccoStudy.pdf. The data on transgender persons is ours.

[17]"U.S.A. Suicide: 2002 Official Final Data," prepared for the American Association of Suicidology by John L. McIntosh, Ph.D. Official data source: Kochanek, K.D., Murphy, S.L., Anderson, R.N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics DHHS Publication No. (PHS) 2005-1120. Population figures source: table I, p.108. of the National Center for Health Statistics (Kochanek et al., 2004), see http://www.sprc.org/library/event_kit/2002datapgv1.pdf

[18]National Institute of Mental Health. (2010). Suicide in the U.S.: Statistics and Prevention. Retrieved September 22, 2010, from http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml

[19]American Foundation for Suicide Prevention. (2010). Risk Factors for Suicide. Retrieved September 22, 2010, from http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=05147440-E24E-E376-BDF4BF-8BA6444E76. According to the Substance Abuse and Mental Health Services Administration, adults who have had a major depressive episode—the leading risk factor for suicide—in the previous twelve months had an attempt rate of 10.4%.

[20]National Institute of Mental Health. (2010). Suicide in the U.S.: Statistics and Prevention. Retrieved September 22, 2010, from http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml

[21]The National Transgender Discrimination Survey met the standards established by Pennsylvania State University's Institutional Review Board (IRB) to ensure the confidentiality and humane treatment of our survey participants. We are grateful to Dr. Susan Rankin, a nationally recognized LGBT researcher, for hosting our study through Pennsylvania State University's Consortium on Higher Education.

[22]We are grateful to the LGBT Tobacco Control Network for this funding, which undoubtedly improved access to the study and allowed us to explore levels of tobacco use among transgender people.

[23]We use terms in this study that have different meanings across nations, cultures, and regions. For the purposes of analyzing information reported in this study, we necessarily had to develop working definitions that may differ in other contexts.

ACKNOWLEDGEMENTS

We are grateful for the supplemental funding for this study provided by the LGBT Tobacco Control Network.

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